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NGO Networks for Health

Maximizing Access and Quality

At a glance

By Dr. James Shelton

It is well established in the field that access to quality services leads to client satisfaction and to an increase in continued contraceptive use. To this end, the United States Agency for International Development (USAID) has developed MAQ, a joint initiative of USAID, collaborating agencies, and various country partners to **M**aximize clients' **A**ccess to and improve the **Q**uality of family planning and other reproductive health services. The job of MAQ is to ensure that state-of-the-art practices regarding access and quality are promoted and used in the field. MAQ operates according to the following basic principles: interventions should be practical and realistic, client-centered, evidence-based, collaborative, field-oriented, and reflect the wisdom of international consensus and local reality. Overcoming barriers to access, identifying and strengthening sources of client satisfaction, and enhancing provider skills and expertise are key elements to increasing the likelihood of continued contraceptive use.

CLIENT and SERVICE BARRIERS to ACCESS

For many clients, just 'getting **to** the door' (of a clinic) is fraught with obstacles. There may be numerous socio-cultural barriers, such as norms about family planning, gender issues, lack of women's autonomy, fears, rumors, and myths about different methods of family planning. Distance poses yet another barrier to many women, as do numerous competing demands on their time such as child-care, household chores including carrying water and finding firewood, and other work outside the home. In addition, the client may not be convinced that contraception is effective, or she may not be able to afford it.

Some clinics are very busy, understaffed, or otherwise hard to get into with complex registration processes, scarce appointment slots or no provision for advance appointment making, and require repeated queuing. In Santa Barbara, Brazil, for example, clients could only schedule an appointment on certain days and could only schedule appointments one to two months in advance "Getting an appointment is like winning the lottery," one client observed. The husband of another client explained that he goes to the clinic "at three in the morning, and at seven my wife comes and stays in line, and I go to work."

Women also confront obstacles on the **other** side of the threshold, obstacles that affect their satisfaction and whether they are likely to come back. Among other things, they may wonder:

Will my method of choice be available?
Will the provider give it to me?
How long will I have to wait?
Will there be a long series of steps or delays in the process?
Will the provider be nice to me?
Will I get the counseling and instructions I need?
Can I afford the services?
Will I get follow-up care if I need it?

'MEDICAL' BARRIERS to ACCESS

Medical barriers are additional obstacles standing in the way of many potential clients. In Pakistan, for example, one study showed that providers often imposed unnecessary age restrictions on access to oral contraceptives. Twenty-nine percent

of providers would not give oral contraceptives to a person younger than 25, and 43 percent would not give them to a person older than 30, thereby excluding approximately 40 percent of the clientele seeking this contraceptive method. Another example of a medical barrier appears in a study done by the Population Council in five African countries in the mid-1990s. This study showed a high percentage of providers denying injectibles to women who had not had children. In Kenya, for example, 95 percent of providers imposed this restriction.

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The menstrual requirement presents yet another major medical barrier to women seeking family planning. A study based on Kenyan data showed that 45 of a hypothetical 100 women seeking family planning services would not be menstruating, and of these, 35 women would be sent home to await menses. Unfortunately, these women would be at risk of becoming pregnant before their next menses. To overcome this barrier, providers can be given a checklist of questions to use with non-menstruating clients.[1] The answers obtained to these questions then determine whether or not it is appropriate to provide non-menstruating women with contraceptives. Medical barriers are not insurmountable, but persuading providers to adopt new behaviors is a huge task.

WHAT DETERMINES CLIENT SATISFACTION?

A woman may attend a family planning clinic, but how can we guarantee she comes back? How can we ensure her satisfaction with the service and the family planning method she is given? Numerous studies have attempted to identify factors that contribute to client satisfaction. One such study in China found that providing structured counseling about side effects improved the chances of method continuation. Another determining factor in client satisfaction is whether the client gets her contraceptive method of choice. A study conducted in Indonesia found that in 90 percent of cases, a woman who received her method of choice continued using the method. Unfortunately, this outcome is by no means assured, since clients don't always get their method of choice, in some cases because of stockouts and in others due to provider bias. Too often providers will push the contraceptive method they think is best or is less work for them. "Sometimes we're in a rush," a doctor in El Salvador explained, "and there are many patients. So we just choose the easiest method for us."

We know that there is a strong correlation between certain provider behaviors and increased client satisfaction and method continuation. Where providers are (1) appreciative of the client's need for privacy; (2) responsive to client questions; (3) sympathetic to problems and needs; (4) seen as someone the client could depend on for help with problems; and (5) give adequate information, there is increased client satisfaction. Where providers take the time to explain side effects of methods, advantages and disadvantages associated with each, how to use them, what problems to expect, whether the methods prevent sexually transmitted infections, and when to return to the clinic, there is an increased likelihood of method continuation.

[1] An example of such a checklist may be downloaded from: http://www.fhi.org/en/fp/checklistse/chklstfpe/pregckl.html

THE PROVIDER PERSPECTIVE

Providers are a critical variable, affecting both access and quality, but we often know very little about them. We often don't know what motivates them, how they feel about their work, the level of their abilities, or their value systems. One way of increasing provider effectiveness is by using shared learning approaches to in-service training, supervision, and other support. By better understanding the provider we can, in turn, better motivate them.

More attention needs to be focused on how clinic staff organize their work and the clinic workplace itself. Issues such as division of labor, job design and responsibilities, efficient use of space, equipment and other physical resources, supplies, procedural barriers, clinic hours, and client flow require close examination, planning, and orchestration to ensure effective and efficient service provision. An access study in Malawi showed the average waiting time was 2 hours and 22 minutes, and 31 percent of clients were turned away without being seen. Many of the reasons clients were turned away related to how the clinic and work were organized, including lack of supplies or equipment, staff who were too busy or too tired, scheduling excuses (wrong day, time, date), or the staff were 'away' (attending a funeral or working in the garden). Health services need to be designed to meet the needs of the people they are meant to serve.

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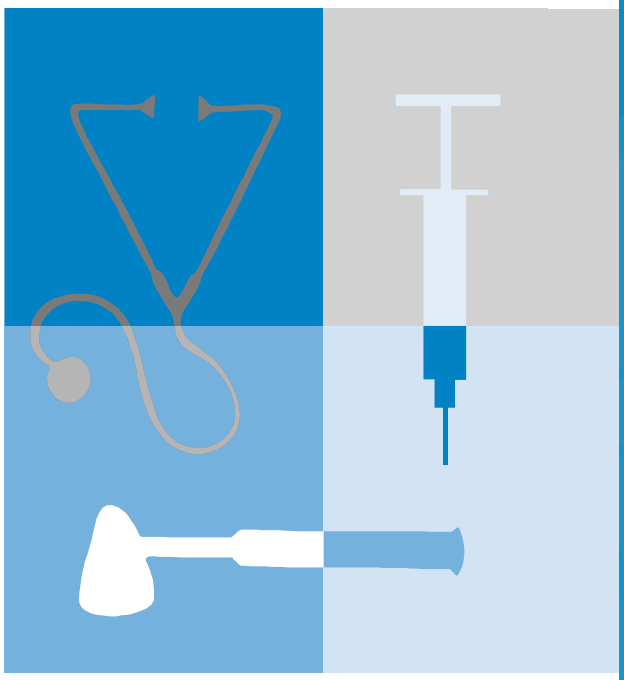

HOW MAQ WORKS

As mentioned earlier, the MAQ initiative is implemented through the joint efforts of USAID, collaborating agencies, host-country partners, and others. To promote best practices, MAQ working group committees were formed around the following topics:

Technical guidance and competence;
Client-provider interaction;
Policy, advocacy, communication, and education;
Management and supervision;
Monitoring and evaluation;
Provider perspective; and
Francophone Region.

Each MAQ committee has two or three collaborating agency co-chairs who gather, analyze, and put together best practices[2] and then consult with USAID in implementing their plans through their respective projects.

In the early 1990s, to cite one example of MAQ at work, many collaborating agencies had their own medical guidelines that included contraindications. Because

[2] An example of a service delivery best practice guideline can be downloaded from http://www.engenderhealth.org/ia/foc/focguide.html

providers interpreted the contraindications in different ways and had many misconceptions, the World Health Organization developed eligibility criteria using evidence-based practices for every method without using the term "contraindication." Subsequently, a number of collaborating agencies took these criteria and successfully applied them to various service delivery points in the field to improve access and quality. In another example, the monitoring and evaluation working group committee developed a short, easy-to-use Quick Investigation of Quality (QIQ) survey of 25 standard indicators that has been used successfully in the field.

In order to improve systems, MAQ promotes the consideration of a set of interventions collectively known as the MAQ Lotus; elements of the MAQ Lotus include: organization of work, leadership, problem-solving, client and community engagement, standards, certification, supplies and logistics, job aids, training, and provider rewards. Identifying and supporting the linkages or synergy between these interventions, in collaboration with other partners, such as the World Health Organization, the United Nations Population Fund, collaborating agencies, and country partners, is a key element in MAQ's success.

For further reading

Analyzing the organizational context for positive client-provider interaction: a leadership challenge for reproductive health. MAQ Paper Vol. 1, No. 1 (2000).

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At a glance

NGO Networks for Health (*Networks*) is an innovative five year global health partnership created to meet the burgeoning demand for quality family planning, reproductive health, child survival, and HIV/AIDS information and services around the world. Funded by the United States Agency for International Development (USAID), the project began operations in June 1998. For more information, contact:

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Networks Technical Support Group encourages and supports health policy makers, program managers, and service providers to:

- become aware of the need to consider related social issues in all aspects of their work;
- understand that individual's perceptions can affect policy making, program planning, and clinical practice; and
- become comfortable in discussing a wide range of issues with colleagues, clients, and other persons at community levels as appropriate in their work.

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